



**COMMUNITY  
DENTAL**

**NEW PATIENT  
PACKET**

Pennyroyal Healthcare Services, Inc DBA Community Dental  
1102 S Virginia Street Suite B - Hopkinsville, KY 42240 - 270-632-3088 - 270-632-6742 (Fax)

*In order to help the check in process, please fill in ALL information.*

## PART A

### Patient Information

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
**Last Name** **First Name** **Middle Name**  
What name would you like to go by? \_\_\_\_\_

**Address:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Cellular:** (\_\_\_\_) \_\_\_\_\_ **Work:** (\_\_\_\_) \_\_\_\_\_  
**Email Address:** \_\_\_\_\_ **Preferred Communication:** ☐ Phone ☐ Text ☐ Email  
**Preferred Phone Contact:** ☐ Home ☐ Cell ☐ Work

**Circle Gender at Birth:** M / F **SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Gender Identification (please choose one):** ☐ Male ☐ Female ☐ Transgender- male-to-female  
Transgender-female-to-male Non-Binary

**Sexual Orientation (please choose one):** ☐ Lesbian or Gay ☐ Straight or Heterosexual ☐ Bisexual  
☐ Something Else ☐ Don't Know ☐ Choose Not To Disclose

**Marital Status:** ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow / Widowed ☐ Unknown

**Education:** (choose the highest education level completed)

☐ None ☐ 1-6 grade ☐ 7-8 grades ☐ some high school ☐ GED ☐ High school diploma ☐ Associates Degree  
☐ Bachelors' degree ☐ Masters' degree or higher ☐ Some College

**Race:** ☐ Native American/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White  
☐ Middle Eastern/North African ☐ Other

**Ethnicity:** ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino  
Other: \_\_\_\_\_

**Preferred Language:** ☐ English ☐ Spanish ☐ Other \_\_\_\_\_  
☐ Interpreter Needed?

We offer interpreter services through AMN Healthcare language services

**Living Situation:** ☐ Homeless ☐ Not Homeless ☐ Transitional ☐ Doubling Up ☐ Street  
☐ Other ☐ Unknown

**Agricultural Worker:** ☐ Migrant ☐ Seasonal ☐ Not an Agricultural Worker

**Are you a U.S. Veteran?** ☐ Yes ☐ No

## **IN CASE OF EMERGENCY**

**Please contact (name):** \_\_\_\_\_ **Phone(s):** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

## **INSURANCE INFORMATION (Complete this section only if your insurance card is not present)**

**Primary Insurance:** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Subscriber Address (if different than the patient):** \_\_\_\_\_

## **RESPONSIBLE PARTY INFORMATION**

**Employment:** ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Retired  
☐ Active Military ☐ Unknown

**Responsible Party Name:** \_\_\_\_\_ **Employer Name:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **Employer Phone:** \_\_\_\_\_

## **Required Information and Acknowledgements**

### **Release of Medical Records**

- In the event that my physician / provider recommends (and I agree to) referral to a specialist, an outside Health Care Center, or other outside medical provider, I hereby authorize Community Dental to release my medical records as required to the indicated specialty physician, provider and/or the referral health center for the purpose of continuity of care.
- I understand that this release of my medical information is required to facilitate a referral (which is made by my Community Dental provider and accepted by me stays in force unless I revoke it in writing to Community Dental.

### **CONSENT for TREATMENT**

- In seeking medical care from Community Dental, I do hereby voluntarily consent to such examination and treatment as is deemed necessary by Community Dental. I understand the practice of medicine is not an exact science, and that diagnosis and treatment involve risks of injury or even death. I acknowledge that Community Dental providers have made no guarantees to me as a result of examination or treatment.

### **Patient Acknowledgement:**

- **Cancellation of Appointments.** I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary. I understand that if I have three missed or cancelled appointments, I may be discharged from the Health Center practice.
- **No Call / No Show.** I understand that missing 3 appointments within 12 months as a no call/no show **may** cause me to be discharged from the practice.
- **15 Minute Grace Period.** I understand the 15-minute grace period policy. If I arrive more than 15 minutes late, Community Dental reserves the right to reschedule your appointment. However, Community Dental may use discretion in allowing the appointment beyond the grace period
- **Notice of Privacy Practices.** I have received a copy of the Notice of Privacy Practices.
- **Responsibility for Payment.** For and in consideration of services rendered, or to be rendered, to the named patient, I or we, or either of us do hereby promise to pay Community Dental the full amount of all charges incurred. I/we understand that Community Dental will file commercial insurance as a courtesy. Community Dental will allow 30 days for the insurance to resolve the outstanding charges.
- **Update Patient Information.** I am required to update paperwork annually. If my paperwork is outdated, I will arrive at least 30 minutes before my scheduled appointment. This allows ample time to complete the necessary forms, update medication list, and ensures the reception team can update electronic records and verify any new or changed insurance before the appointment.

**Patient / Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## V. HOUSEHOLD INCOME INFORMATION

*Note: As a Federally Qualified Health Center (FQHC), we provide Sliding Fee Scales which may help you with your health care expenses. To help us determine if you may qualify, please answer below. This information is only used to obtain the grants we use to help those who do not have insurance and will not affect you in any adverse way.*

What is your annual household income? \_\_\_\_\_ How many people are in your household? \_\_\_\_\_

- ☐ No Income   ☐ Less than 24,999   ☐ 25,000 to 39,999   ☐ 40,000 to 59,999   ☐ 60,000 to 99,999  
☐ 100,000 or more

*If you are interested to know more about our **Sliding Fee Scale Program**, please fill out the enclosed Sliding Fee Scale discount program section below.*

### A sliding scale discount program is available for our uninsured and under-insured patients who may have difficulty paying.

#### **Pennyroyal Healthcare Services, Inc.**

2025 Dental Sliding Fee Schedule  
(Based on 2025 DHHS Federal Poverty Guidelines)  
Effective February 2025

Poverty Level	Class A 100% or below	Class B 101%-125%	Class C 126%-150%	Class D 151%-200%	Class E > 200%
Family Size	\$100	Pay 70%	Pay 80%	Pay 90%	Full Fee
1	\$15,650	\$19,563	\$23,475	\$31,300	\$ 30,121
2	\$21,150	\$26,438	\$31,725	\$42,300	\$ 40,881
3	\$26,650	\$33,313	\$39,975	\$53,300	\$ 51,641
4	\$32,150	\$40,188	\$48,225	\$64,300	\$ 62,401
5	\$37,650	\$47,063	\$56,475	\$75,300	\$ 73,161
6	\$43,150	\$53,938	\$64,725	\$86,300	\$ 83,921
7	\$48,650	\$60,813	\$72,975	\$97,300	\$ 94,681
8	\$54,150	\$67,688	\$81,225	\$108,300	\$ 105,441
For each additional person, add	\$6,330				

**\*\*Patients are required to pay the full cost of labs and appliances (supplies) for dentures, crowns, bridges, extractions, root canals, etc**

**\*\* Covered services include Preventative Dental Services (dental screenings, oral hygiene instructions, oral prophylaxis, topical application of fluoride, x-rays and imaging, and fillings.**

- ☐ Yes, I am interested in information regarding the sliding scale program.
- ☐ No, I am not interested at this time in the sliding scale program and I do not wish to disclose my income.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Once the paper is signed, please return it to the receptionist.**

# HIPAA Authorization for use or disclosure of health information.

This form is for the use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

## I. My Authorization

I authorize the following using or disclosing party: Community Dental

To use or disclose the following health information:

\_\_\_ All my health information

\_\_\_ My health information relating to the following treatment or condition: \_\_\_\_\_

\_\_\_ My health information covering the period from \_\_\_\_ (date) to \_\_\_\_ (date)

\_\_\_ Other: \_\_\_\_\_

The above party may disclose this health information to the following recipient:

Name or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

## II. My Rights

I understand that I have the right to revoke this information, in writing, at any time, except where uses or disclosures have already been based upon my permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I may do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPPA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor or unable to sign, please complete the following:

Patient is a minor: \_\_\_\_\_ years of age

Signature of Authorized Representative: \_\_\_\_\_

\_\_\_ Parent \_\_\_ Legal Guardian \_\_\_ Court Order \_\_\_ Other: \_\_\_\_\_

**Dental History:**

1. What is your main dental concern at this time? \_\_\_\_\_
2. What is the name of your previous dentist? \_\_\_\_\_  
When did you last see your previous dentist? \_\_\_\_\_ Why? \_\_\_\_\_  
When were your last dental x-rays taken? \_\_\_\_\_
3. How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_
4. What other aids do you use to clean your teeth? \_\_\_\_\_
5. Check any of the following that you may have:

- |   |  |   |
|---|--|---|
| <input type="radio"/> Pain in the face                  | <input type="radio"/> Jaw locking or catching            | <input type="radio"/> Difficulty opening mouth    |
| <input type="radio"/> Pain inside the mouth             | <input type="radio"/> Jaw pain or aching                 | <input type="radio"/> Difficulty closing mouth    |
| <input type="radio"/> Pain in your ears                 | <input type="radio"/> Clenching or grinding teeth        | <input type="radio"/> Recent change in bite       |
| <input type="radio"/> Frequent headaches                | <input type="radio"/> Problems chewing                   |   |
| <input type="radio"/> Jaw joint sounds                  | <input type="radio"/> Poorly fitting partial denture     | <input type="radio"/> Lump or swelling in mouth   |
| <input type="radio"/> Teeth sensitive to heat           | <input type="radio"/> Dry mouth                          | <input type="radio"/> Loose teeth                 |
| <input type="radio"/> Teeth sensitive to cold           | <input type="radio"/> Sores or ulcers in mouth           | <input type="radio"/> Missing Teeth               |
| <input type="radio"/> Difficulty flossing between teeth | <input type="radio"/> Burning mouth or tongue            | <input type="radio"/> Crooked teeth               |
| <input type="radio"/> Difficulty brushing between teeth | <input type="radio"/> White, red, or brown mouth lesions | <input type="radio"/> Sore gums                   |
| <input type="radio"/> Food wedging between teeth        | <input type="radio"/> Bad breath                         | <input type="radio"/> Facial swelling             |
| <input type="radio"/> Poorly functioning teeth          | <input type="radio"/> Discolored teeth                   | <input type="radio"/> Snoring                     |
| <input type="radio"/> Poorly fitting complete denture   | <input type="radio"/> Soft teeth, susceptible to decay   | <input type="radio"/> Stop breathing during sleep |
|   |  | <input type="radio"/> Other: _____                |

- |  |          |
|--|----------|
| 6. Are you currently experiencing any dental pain or discomfort?       | Yes / No |
| 7. Do you have any special concerns about your mouth or teeth?         | Yes / No |
| 8. Are you nervous about dental treatment?                             | Yes / No |
| 9. Have you ever had an unpleasant experience in a dental office?      | Yes / No |
| 10. Have you ever experienced complications with a dental treatment?   | Yes / No |
| 11. Do your gums bleed when you brush or floss?                        | Yes / No |
| 12. Have you ever been given instructions on how to brush or floss?    | Yes / No |
| 13. Have you ever been treated for gum disease?                        | Yes / No |
| 14. Have you ever had an injury to your face, head, or neck?           | Yes / No |
| 15. Do you use tobacco products in any form (smoking, chewing, snuff)? | Yes / No |
| 16. Do you have any oral habits that might affect your dental health?  | Yes / No |
| 17. Do you like the way your teeth look?                               | Yes / No |
| 18. Have you ever worn braces or received orthodontic treatment?       | Yes / No |
| 19. Do you receive fluoride treatment for your teeth?                  | Yes / No |
| 20. Do you have any other concerns not listed above?                   | Yes / No |

If yes, please explain: \_\_\_\_\_

**For Pediatric Patients:**

- |  |          |
|--|----------|
| 21. Has your child ever been treated in an emergency room?         | Yes / No |
| 22. Does your child have an emotional, mental or nervous disorder? | Yes / No |
| 23. Do you think your child will be an uncooperative patient?      | Yes / No |
| 24. Has your child ever sucked a thumb or finger?                  | Yes / No |
| 25. Has your child inherited any family dental characteristics?    | Yes / No |
| 26. Does your child receive any form of fluoride?                  | Yes / No |

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The Preceding answers are true and correct to the best of my knowledge. If there are changes, I will inform the doctor at my next appointment.

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Patient Signature

Date

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Patient Name (Please Print)

<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>○ Congestive Heart Failure</li> <li>○ Heart Attack</li> <li>○ Angina Pectoris or Chest Pain</li> <li>○ High Blood Pressure</li> <li>○ Heart Murmur</li> <li>○ Mitral Valve Prolapse</li> <li>○ Rheumatic Fever</li> <li>○ Congenital Heart Defect</li> <li>○ Artificial Heart Valve</li> <li>○ Arrhythmia</li> <li>○ Pacemaker/Defibrillator</li> <li>○ Heart Transplant</li> <li>○ Aneurysm</li> <li>○ Other Heart Problem</li> </ul>	<b>Gastrointestinal</b>	<ul style="list-style-type: none"> <li>○ Stomach/ Intestinal Ulcers</li> <li>○ Colitis</li> <li>○ Persistent Diarrhea</li> <li>○ Hepatitis</li> <li>○ Liver Disease</li> <li>○ Yellow Jaundice</li> <li>○ Cirrhosis</li> <li>○ Eating Disorder</li> </ul>	<b>Genitourinary</b>	<ul style="list-style-type: none"> <li>○ Urinate Frequently</li> <li>○ Kidney/bladder problems</li> <li>○ Dialysis</li> <li>○ Kidney Transplant</li> <li>○ Sexually Transmitted Diseases</li> <li>○ HIV Positive</li> <li>○ Multiple Sexual Partners</li> </ul>
	<b>Hematologic</b>	<b>Pulmonary</b>	<ul style="list-style-type: none"> <li>○ Hay Fever</li> <li>○ Sinus Problems</li> <li>○ Allergies or hives</li> <li>○ Asthma</li> <li>○ Chronic Cough</li> <li>○ Emphysema</li> <li>○ Chronic Bronchitis</li> <li>○ Tuberculosis (TB)</li> <li>○ Breathing Difficulties</li> </ul>	<b>Other</b>	<ul style="list-style-type: none"> <li>○ Frequent Sore Throats</li> <li>○ Enlarged Lymph Nodes</li> <li>○ Use Alcohol</li> <li>○ Use injectable Drugs</li> <li>○ Drug or Alcohol Addition (current or recovering)</li> <li>○ Tumor or Cancer</li> <li>○ Radiation Therapy</li> <li>○ Chemotherapy</li> <li>○ Drug reactions</li> </ul>
			<b>Derma/Muscular</b>		<ul style="list-style-type: none"> <li>○ Allergy to Latex</li> <li>○ Skin Rash</li> <li>○ Dark Moles/ Changes in skin</li> <li>○ Night Sweats</li> <li>○ Osteoarthritis</li> <li>○ Rheumatoid Arthritis</li> <li>○ Systemic Lupus</li> <li>○ Artificial Joint</li> </ul>
<b>Neurologic</b>	<ul style="list-style-type: none"> <li>○ Blood Transfusion</li> <li>○ Anemia</li> <li>○ Hemophilia</li> <li>○ Leukemia</li> <li>○ Sickle Cell Anemia</li> <li>○ Tendency to bleed longer than normal</li> </ul>	<b>Endocrine</b>	<ul style="list-style-type: none"> <li>○ Diabetes</li> <li>○ Thyroid Disease</li> <li>○ Taking Cortisone or other steroid</li> </ul>	<b>Disease, Problem or Conditions not listed:</b>	<p>_____</p> <p>_____</p> <p>_____</p>
			<ul style="list-style-type: none"> <li>○ Vision Problems</li> <li>○ Glaucoma</li> <li>○ Earaches, ringing in ears</li> <li>○ Hearing Loss</li> <li>○ Severe Headaches</li> <li>○ Fainting or Dizzy spells</li> <li>○ Stroke</li> <li>○ Epilepsy, Seizures, or Convulsions</li> <li>○ Psychiatric treatment</li> <li>○ Panic Attacks</li> <li>○ Phobias</li> </ul>		<p>_____</p> <p>_____</p> <p>_____</p>

27. Are you currently taking bisphosphonates? (ie. Fosomax, Reclast, Boniva, Actonel, Zometa)	Yes / No	List any medications you are currently taking or supposed to be taking: _____
28. Has a previous dentist or physician required you to take an antibiotic before receiving dental treatment? (Usually because of heart defect or artificial joints)	Yes / No	_____
29. Have you ever had a reaction to an anesthetic?	Yes / No	_____
30. When you walk up stairs, do you stop due to pain in the chest or fatigue?	Yes / No	_____
31. Do your ankles swell during the day?	Yes / No	_____
32. Have you gained or lost more than 10 lbs in the past year unintentionally?	Yes / No	_____
33. Are you on a special diet?	Yes / No	_____
Women: Are you pregnant or possibly pregnant?	Yes / No	_____
		_____
		_____
		_____
		_____